Claim No.:

Date of Incident:

LISA MADIGAN
Attorney General - State of Illinois
Crime Victims Compensation Bureau

LIFE INSURANCE REPORT - ("E")

IF YOU DO NOT HAVE INSURANCE, PLEASE WRITE "NONE".
SIGN AND DATE THIS FORM.

THIS DOCUMENT IS TO BE FILLED OUT AND SIGNED BY THE INSURANCE AGENT AND RETURNED TO THE ATTORNEY GENERAL'S OFFICE.

Insured's Name:_____ **SS#**_____
Insured's Address:_____
Street
_____
City **State** **Zip Code**
Name of Insurance Company:_____
Address of Insurance Company:_____
Street
_____
City **State** **Zip Code**
Telephone Number of Insurance Company:_____

Policy #:_____ **Policy Face Value: $**_____

BENEFICIARY OF POLICY:_____ **Amount Paid: $**_____

Please note: A person who the Court of Claims finds has willfully misstated or omitted facts relevant to the determination of whether compensation is due under this Act or of the amount of that compensation, shall be denied compensation under this Act and be guilty of a Class A misdemeanor.

Under penalties of perjury, I declare that to the best of my knowledge, all of my answers are true, correct and complete.

Name of Preparer:_____ **Date:**_____/_____/_____
(Please print or type.) **MO** **DAY** **YEAR**

Signature of Preparer:_____

Title:_____ **Telephone #** _____

RETURN TO: **LISA MADIGAN, ATTORNEY GENERAL**
CRIME VICTIMS COMPENSATION BUREAU
100 West Randolph Street - 13th Floor
Chicago, Illinois 60601

Contact (312) 814-2581 if you have any questions or need assistance.

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

CLAIM NO.: 04cv2561

DATE OF INCIDENT: 08/22/2003

Name Of Child	Child's Date of Birth	Child's Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Attorney General of Illinois Crime Victims Bureau	100 W. Randolph Street - 13th Floor Chicago, IL 60601

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number

_____ Identifying information (includes date and place of birth, parents' name)

_____ Monthly Social Security benefit amount

_____ Monthly Supplemental Security Income payment amount

_____ Information about benefits/payments I received from _____ to _____

_____ Information about my Medicare claim/coverage from _____ to_____

(Specify)_____

_____ Medical Records

_____ Record(s) from my file (specify)_____

_____ Other (specify)_____

I am the individual to whom the information / records applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature:_____

(Show signatures, names and addresses of two people if signed by mark.)

Date:_____ Relationship:_____